PROVIDER SERVICE OFFICE
ELECTRONIC DATA INTERCHANGE
OPTION SELECTION FORM

Please check one of the following:

_____ Begin Registration _____ Terminate Registration _____ Change Options

Provider Name (DBA): _____

Denti-Cal ID: _____ Service Office: _____

Address: _____

City: _____ State:_____ Zip: _____

Contact Name: _____ Phone Number: _____

Software/Practice Management System: _____

EDI INPUT/OUTPUT OPTIONS

Identify the INPUT FROM and RETURN OUTPUT OPTIONS for your office in the fields below.
For assistance, contact EDI Support at (916) 853-7373.

INPUT FROM: _____ Service Office (SO)
_____ Billing Office (BO)
_____ Clearing House (CH) (Name: _____)

*** ***YOUR VENDOR WILL ASSIST YOU IN COMPLETING THE FOLLOWING*** ***

Unique Clearing House ID# Required? YES NO
Submitter ID#:_____
Provider ID#:_____ Provider Site ID#:_____

You will submit Claims, TARs and Adjustments (ANSI X 12 837). When available, you will submit TARs (ANSI X 12 278).
Will you also submit: RTDs electronically? YES NO
NOAs electronically? YES NO
Claim Status Inquiry (ANSI X 12 276)? YES NO

RETURN OUTPUT OPTIONS when available (standard options are shaded):

EDI Document	Requested? (Circle One)		Send To (Circle One)		
Electronic RTDs	**YES**	NO	SO	BO	CH
Electronic NOAs	**YES**	NO	SO	BO	CH
Electronic EOB Supplemental Claim Data (If YES, CIRCLE ONE: SUMMARY or DETAIL)	YES	NO	SO	BO	CH
Electronic X-Ray/Attachment Labels (CIRCLE ONE: 1-UP or 3-UP)	**YES**	NO	SO	BO	CH
Report of Documents Awaiting Return Information (CP-0-978-P)	**YES**	NO	SO	BO	CH
Report of EDI Documents Received (CP-0-973-P)	**YES**	NO	SO	BO	CH
Remittance Advice (ANSI X 12 835)	YES	NO	SO	BO	CH
Claim Status Inquiry Response (ANSI X 12 277)	YES	NO	SO	BO	CH
Treatment Authorization Request & Response (ANSI X 12 278)	YES	NO	SO	BO	CH

_____ _____
Authorized Applicant's Original Signature Date

FOR DENTI-CAL USE ONLY	
C/H ID:	
Remote ID:	
P/W:	
CV:	

Return completed form to:

Medi-Cal Dental Program
Provider Services
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609